Chronicle User Manual

Chronicle User Manual 1
Glossary 3
General terminology and conventions in Chronicle, manual 3
Log In and Log Out 5
Browser requirements 5
Logging in 5
Recovering a forgotten username or password 6
Switching between sites 6
Logging out 6
Patient Administration 7
Creating a New Patient 7
Patient login and password creation 7
Patient's Primary Provider and PCP 7
Assigning the patient to a Cohort 7
Creating a patient referral 8
Saving the patient 8
Patient List view 8
Patient Filters 8
Generating Patient Letters 9
Patient Reports 9
Snapshot Repot 10
Diabetes Self-Management Education Record Repot 10
Managing patient cohorts 10
Viewing an individual patient's records 10
General Information 10
Resetting a patient's username or password 11
Modifying a patient's Physicians 11
Managing a patient's referrals 11
Managing a patient's educational sessions 11
Managing a patient's cohorts 12
DSME Assessment 12
Health Status 12
Behavior Change Objectives 12
Adding a new (baseline) Behavior Change Objective 13
Updating the status of an existing objective 13
Viewing and editing an existing objective status 13
Clinical Data and Labs 13
Adding a new clinical data or lab test result 14
Adding multiple clinical data or lab test results using a Lab Sheet 14
Editing or deleting an existing test result 15
Medications 15
Adding a medication 15
Recording a medication change event 16
Editing or deleting an existing medication or change event 16
Recording a stop medication event 16
Creating a new (custom) medication 16
Contact History 17
Notes 17
Class Administration 18
View complete list of classes 18
Creating a new class or new 1:1 18

Entering Class Information 19
Defining Class Schedule 19
Editing or deleting an existing class session 20
Entering and editing the class roster 20
Exporting a patient list for a class 20
Sending letters to every patient in a class 21
Documenting a DSME class 21
Defining the lesson plan for the class 21
Documenting individual patient educational progress, barriers and support plan 21
Documenting additional comments and notes 22
Documenting patient attendance 22
Documenting educator time spent with class 23
Documenting patient follow-ups 23
Managing and using Class Templates 24
Creating a new Class Template 24
Creating a new Class from a Class Template 25
Other Administrative Tasks 26

Glossary

Site – Under ADA recognition, a recognized program may have or more sites associated with it. ADA has two different site types, either multi-site or expansion site. For the purposes of Chronicle, there is no difference between these types- all sites are the same. A site consists of a number of patients and those patient's educational documentation. Each patient is associated with one (and only one) site. A patient cannot be associated with multiple sites. An educator can be associated with one or more sites.

Initial Patient Self-Assessment (PSA) – A screening questionnaire that can be completed online by the patient prior to receiving DSME.

Diabetes Education and Progress Record (DEPR) – The documentation tool used to record all information about a class, including the class's patient roster, attendance, topics covered, and educator time spent with the class. Patient follow-up information is also stored in the class's DEPR.

General terminology and conventions in Chronicle, manual

Collapsing and expanding (hiding and revealing) menu items
Chronicle's interface has many menus, lists and data fields that can often be collapsed and expanded (or hidden and revealed). These collapsible elements will have a disclosure triangle like ▸ or ▼ icon to the left of the element name. Clicking a collapsed disclosure triangle (▸) will cause the ▸ to change to a ▼ and the collapsed (hidden) data will be expanded (revealed). Conversely, clicking an expanded disclosure triangle (▼) will cause the ▼ to change to a ▸ and the expanded (revealed) data will become collapsed (hidden).

Italics text
Words in this manual that are in italics font refer to words that are part of the Chronicle interface, such as buttons, menus, and links.

Underlined text
Phrases that are underlined in the manual refer to other sections of the manual.

Pop up windows in Chronicle interface
Many data entry and editing windows "pop up" above the normal Chronicle interface. These don't actually open a new window in your browser. Instead they "float above," with the normal Chronicle interface dimmed out in the background. For example, when click a pencil to edit information, or when adding clinical data. When these pop up windows are present you can't access the Chronicle interface below. However you can move the pop up window by dragging it by the orange title bar (the top of the pop up window). Moving a pop up window my help you see other parts of the page that the popup window was obscuring.

Dimmed (inactive) elements
Chronicle attempts to guide your data entry by only allowing you to enter data into areas that are applicable to what you're documenting. For data areas that aren't applicable or that are conflicting, Chronicle will dim those elements so that you don't enter erroneous data. For example, when entering clinical data test results, if you check the box indicating that you don't know the date of the test, then the *Date Performed* text box will dim indicating that it is inactive and you can't enter a date. If you uncheck the don't know date check box, the *Date Performed* text box will un-dim and you'll be able to enter a date.

Back to Top

Edit pencils
Throughout the Chronicle interface, a small yellow pencil always indicates something that can be edited. When an item has an edit pencil to the left of it, clicking the pencil will allow you to edit the item.

Help links, Support submissions
Every page in Chronicle has a *Help* link near the upper right corner of the page. There are also help links within most popup windows throughout the site. Clicking any of these *Help* links will display useful information and instructions relevant to the task that you are working on. Be sure to consult these Help links if you're unsure about some feature of the system. If after consulting the Help link and this User Manual you still require assistance, there is a Support link at the top right of every page. You can use this to submit support requests to ADA.

Back to Top

Log In and Log Out

Browser requirements

Chronicle can be accessed using any modern Internet browser, although some browsers offer an improved experience and are recommended. This is the list of browsers that are confirmed to work with Chronicle:

On a Windows-based PC
- Internet Explorer version 7.0 and above
- Firefox version 3.0 and above

On a Apple Macintosh
- Safari version 3.0 and above
- Firefox version 3.0 and above

Your computer's display resolution should be set for 1024x768 or higher. If you log into Chronicle and some parts of the interface are cut off or seem to continue off the edge of the screen, then your resolution might be set too low.

To change your display resolution when using Windows XP, follow these instructions:
http://windows.microsoft.com/en-US/windows-xp/help/setup/change-monitor-resolution
http://windows.microsoft.com/en-US/windows7/Change-your-screen-resolution

To change your display resolution when using Apple OS X, follow these instructions:
http://support.apple.com/kb/HT2490#I2

Logging in

To being using Chronicle enter this domain name into your web address bar:

https://edu.chroniclediabetes.com/

> **TIP:** You can bookmark this address for quick access in the future.

This will bring you to the login page. Enter your *Username* and *Password* and click *Secure Login*. If you enter an incorrect username or password you will be notified that the information was incorrect. If you believe you entered the information incorrectly you can re-enter your username or password. If you don't remember your username or password, click the *Forgot your username or password* link and follow the instructions under Recovering a forgotten username or password to reset your password. After five consecutive login failures, your account will become suspended for five minutes. If this happens, wait five minutes and then you can attempt to log in again.

Please note that each Chronicle user has a unique user account, with his or her own username and password. This account is used to document everything you do in Chronicle, so for security and HIPAA compliance it is important that you never log in using another person's account information, never "share" accounts, and never give your account information to anyone else. If you suspect that someone else has information about your account credentials, you should ask your Program Coordinator to change you password immediately.

Once you have logged in you'll notice your name will be displayed in the lower left of the screen, and your site's name will be displayed in the lower right of the screen.

Back to Top

Recovering a forgotten username or password

If you forget your username or password, click the *Forgot username or password* link on the login page. This will allow you to enter your email address and have an encrypted link emailed to you. Click this link to be taken back to a page where you can reset your password. If you do not have access to the email account that you previously registered with Chronicle, you'll need to contact your Program Coordinator and have the password reset manually.

Switching between sites

Each educator can be assigned to one or more Chronicle sites. Each of those sites has its own patient population and classes. When you are logged into Chronicle, you can only see the information (patients, education sessions, etc.) for a single site. The name of the site that you're actively viewing is shown in the lower right corner of the window. Even if the program coordinator for your program has assigned you to multiple sites, you can only see the information for one site at a time. To see information for a different site that you are also assigned to, you must switch to viewing that site. To do this, click on the name of the current site in the lower right corner of the window, which will bring up a box displaying the names of all the sites that you are assigned to. Click on the name of the site that you would like to view. This will switch you to that site. Note that the patient list and education list have changed to show the information for this site. When you log out of Chronicle, the system remembers which site you were viewing last, and will return you to that site the next time you log in. If you are currently only assigned to a single site, then you are not able to switch sites. Nothing will happen when click on the name of your site in the lower right corner of the window.

Logging out

When you are finished using Chronicle, or if you're going to be away from your computer, you should log out of Chronicle. You log out by clicking the *Logout* link in the upper right corner of the screen. This will log you out of the system. You should then close your browser window to ensure that the Chronicle session is completely over. Note: for security purposes Chronicle will automatically log you out after 30 minutes of inactivity.

Back to Top

Patient Administration

To access the patient administration section, click on the *Patients* tab in the top navigation bar. This will display a list of all of the patients currently enrolled at your site. Note that if you already have a patient record open you will have to click on the *Return to Patients List* button to return to the full list.

Creating a New Patient

> **IMPORTANT:** If you are assigned to multiple sites within your program, then be sure that you are viewing the correct site before adding a new patient. New patients are added to the site that you're currently viewing. For more information about witching between sites, see the section Switching between sites under Log In and Log Out.

To create a new patient at your site, click on the *Create New Patient* button to bring up the *Create New Patient* window. This window is divided into a number of sections that allow you to enter information about the new patient. Some information is required, and is indicated by a red dotted line under the text field. The Date of Birth field uses Chronicle's normal date entry text box and calendar widget to make date entry quick and accurate. For more information about entering dates in Chronicle, see the section Date Entry under Other Administrative Tasks.

Patient login and password creation

When you create a new patient, Chronicle offers to automatically create login credentials (login name and password) for the patient. These login credentials can be used by the patient to log into the patient component of Chronicle and complete their initial patient self-assessment (PSA). By default Chronicle will create a login name that contains the patient's first name, last name, and some random numbers. Chronicle also creates a password that is identical to the login name. (The patient is required to change their password when they first log into Chronicle.) To have the login credentials automatically created leave the box checked next to *Auto Generate Login Information*. If you'd like to create your own login name and password, simply uncheck the *Auto Generate Login Information* checkbox and fill in the fields with the desired login name and password.

Patient's Primary Provider and PCP

Each patient can have a primary provider (or primary care physician) designated for them. To select the patient's primary provider, click the *Select* pencil to the right of the *Primary Provider / PCP* text box, which will bring up the *Select Provider* window. This window lists all of the providers that are currently entered for your site. To select a provider, click on the provider's name and then click *Select Provider*. If you later want to un-select the provider, click the red *Unassign* link to the right of the *Primary Provider / PCP* text box. For more information about adding providers and managing the provider list, see the section Primary Provider and PCP Management under Other Administrative Tasks.

Assigning the patient to a Cohort

Each patient can be assigned to one or more cohorts. Cohorts are not related to educational classes- they are simply a way to categorize patients into groups of similar patient types. For example, you might set up an "Insulin Starts" cohort and assign all such patients to it so that you can maintain an ongoing list. When initially creating a new patient you can assign her to a cohort. Click the click the *Select* pencil to the right of the *Assign to Cohort* text box to bring up a list of all cohorts that have been created at your site, and select the cohort from the list. If you later want to un-select the cohort, click the red *Unassign* link to the right of the *Assign to Cohort* text box. For

Back to Top

more information about adding cohorts and managing the patients in each cohort, see the section Managing patient cohorts under Patient Administration.

Creating a patient referral

If the patient was referred to your site and you would like to record that referral, you can document that referral here. Check the checkbox at the top of the *Referral* section to enable the referral fields. Enter the date of the referral, document who the Referring Provider was (or if it was a self-referral), and record a reason for the referral. Note that documenting the patient's referral is not required, or could be added at a later time. For more information about adding and managing a patient's referrals. see the section Managing a patient's referrals under Patient Administration.

Saving the patient

If you change your mind and decide not to add the new patient, you can click *Cancel Changes* to stop adding the new patient without saving any of the information you've entered. After you have completed all of the information, click the *Save Changes* button in the lower right of the window. This will add the patient to your site and will open the patient's record. You'll be on the *General Information* page of the patient's record.

Patient List view

The *Patient List* gives you a list of all of the patients currently enrolled at your site. Note that if you already have a patient record open you will have to click on the *Return to Patients List* button to return to the full list. The list of patients is shown in groups of 25 per page. Use the navigation at the top right of the patient list to page through all of your patients. To search for a specific patient, enter into the *Search* box any part of the patient's name and hit Enter. Selecting a patient status from the *Patient Status* drop down will limit the list to show only patients of that status. Selecting a cohort from the *Limit results by Cohort* drop down will limit the list to show only patients in that cohort. Click on the *X Clear Filters* link to the right of the boxes to clear the search or filter (and see the full patient list).

In each patient row listed in the *Patient List* are links to create a *Snapshot Repot* or to *Generate Letters*. These functions are discussed in detail in the sections Generating Patient Letters and Snapshot Repot respectively. Clicking on a single patient row will open the complete record for the patient.

Patient Filters

The *Patient Filter* allows you to view a subset of your patient population that meets a defined set of criteria. Filters can be created, customized, and then saved for quick recall. If the patient filter that you would like to view has already been defined, select it from the drop down box and the patient list will update to show only the patients meeting the defined criteria. From here you can interact with the patient list normally (scroll through the list, click a patient to open the patient's record, etc.) or you can export the filtered patient list into an Excel file by clicking the *Export Results* link. To return to the full list of patients, click the *Clear Filters* link.

To create new patient filter, first click the *New Filter* link to open the *Advanced Patient Filter* window. Here you are able to define a number of criteria that will be used to display the patients that meet all of the criteria. For example, let's say you want to see all of your elderly female patients with an A1c above 8, you can add the following three filters to arrive at that subset:

Back to Top

- For the first filter, select *Demographics* from the first drop box, and *Gender* from the second drop box. In the third drop box select *Is* from the list. In the fourth drop box select *Female* from the list. This completes the process for defining the first filter.
- To add a second filter, click the green (+) button. In the first drop box select *Demographics* and then select *Age* from the second drop box. In the third drop box select *Is greater than* from the list. In the fourth box enter the value *75*. This completes the process for defining the second filter.
- To add a third filter, click the green (+) button. In the first drop box select *Clinical Data* and then select *HbA1c* from the second drop box. In the third drop box select *Most recent value is greater than* from the list. In the fourth box enter the value *8*. This completes the process for defining the third filter.

When you have all of the filters defined, click the *Save Filters* button. This will close the *Advanced Patient Filter* window and will update the patient list to only show patients that meet the defined criteria. In the left navigation pane will be displayed the *Selected Filters* that are currently defining the patient list. To change any of these filters, click the *Update Filters* link. If you would like to save this patient filter (so that anyone from your site can quickly select it from the drop down in the future) click the link that says *Click here to save your changes* and give the filter a descriptive name. To return to the full patient list, click *Clear Filters*.

Generating Patient Letters

Chronicle allows you to generate custom letters for individual patients or multiple patients at a time. The *Letter Generation Wizard* can be launched from a number of locations within Chronicle, including from the main *Patient List*, within an individual patient's record, and also within the *Education* pages. If you click the *Generate Letters* link from within the *Patient List*, the *Letter Wizard* will be launched. For Step 1, select the letter you'd like to create from the drop down list. For Step 2, select the patient(s) from the patient selection tables that you would like to receive the letter. The table on the left contains a list of *Recently Added Patients* at your site. You can scroll through the patients or search for a specific patient using the search box. The table on the right contains a list of the selected patients. A customized letter will be generated for each of the patients in the right-hand list. By default, the patient you were viewing when you evoked the *Letter Wizard* will already be in the recipients list. To add more patients to the list, click on the patient's name in the left-hand list to move them to the right-hand list. Conversely, to remove a patient from the letter list, click on her name in the right-hand list to move them back to the left-hand list. Once you have the all the patients for whom you want letters in the right-hand list, click the *Preview Letter* button. If this preview looks correct, click *Download Letters* in the upper right corner. You will be prompted to save the letter file to you computer. Once this file has been saved to your computer you can open it in Microsoft Word or other text editing application, where you can edit it, apply your letterhead, and print it.

If you'd like to create a new letter, or if you'd like to edit an existing letter, click the *Launch Letter Manager* link (either from within the *Letter Wizard*, or from the left navigation pane in a patient's record). This will allow you to modify the letters that you site has stored in Chronicle. For details about editing and managing letters, see the section Letter Management under Other Administrative Tasks.

Patient Reports

There are a number of preconfigured reports that you can generate for a patient. Select the desired report from the drop down box and click the *Generate* button. This will open the selected report in a new window. Reports can be printed out using your computer's normal printing method.

Snapshot Repot

This report gives an overview of the data about a specific patient. The left column contains lists of the patient's current medications, recent interventions, topics that were covered during the educational sessions, and the patient's goals (and their change rate). The right column of the report contains clinical data, with historical values listed in a table and a graph displaying the change over time.

Diabetes Self-Management Education Record Repot

This report contains the information that was documented for the patient's educational session(s). This includes the pre assessment and post evaluation of the patient's ability in the nine ADA topic/learning objectives, class methods and materials, barriers and DSMS plan. All of the educational information included in this report will represent the most current information documented in Chronicle. For example, if the patient attended multiple education sessions over a period of years, the information on this report will display the information from the most recent sessions.

Managing patient cohorts

Cohorts can be assigned when you first create a new patient, or you can add and remove patients from cohorts afterwards. When on the *Patient List* page, click the *Manage Cohorts* button located near the upper left of the window. This will bring up the *Manage Cohorts* window with a list of all of the cohorts currently set up at your site. If you'd like to add a new cohort, click the *Add Cohort* button and give it an identifiable name. You can select patients from the list to be in the cohort. This window uses Chronicle's standard patient selector. The column on the left (*Recently Added Patients*) lists recent patients. The column on the right (*Patients in cohort*) lists the patients that are members of this cohort. To add a patient to this cohort, find her name in the left column and click on her name. This will add the patient to this cohort. To remove a patient from this cohort, find her name in the right column and click on her name to remove it from the cohort. When you are done, click *Save Changes* to have the new cohort added to the list.

To add or remove patients from am existing cohort, or to change the name of the cohort, select the cohort from the list and click *Edit Selected Cohort*. This brings up the *Edit Cohort* window, with the name of the cohort that you're editing in top text box. You can rename the cohort by editing the existing name. After you are done adding or removing patients from the cohort, click the *Save Changes* button. For more information about using Chronicle's patient selector, see the section Patient selection interface under Other Administrative Tasks.

Viewing an individual patient's records

When you are in the *Patient List*, you can click on an individual patient row to open that patient's record. After you've opened a patient record, you'll initially be in the *General Information* section. You can navigate through the various sections of the patient's record by clicking the tabs in the left navigation pane. Just below those tabs bar is a box where you can generate *Patient Reports*. Select a report from the list and click the button below to generate that report. Below that is the *Generate Letter* box. You can select a letter from the list and click the button below to generate that letter.

General Information

Clicking the *General Information* button from the left navigation pane displays general information about the patient. Any of the data on this page can be edited by clicking the pencil above that section of information.

Back to Top

Resetting a patient's username or password

When you add a new patient to Chronicle, the system automatically sets up a username and password for the patient. By default, the username and the password for a new patient are the same. For example, if you add patient Nancy Johnson, if her username might be nancyjohnson12, then her password will also be nancyjohnson12. Thus if the patient hasn't logged into Chronicle patient portal yet, then you can just tell them to use the same thing for their username and password.

The first time the patient logs into Chronicle they are required to change their password. If the patient later forgets what they changed the password to, **you cannot retrieve it for them**- instead you need to reset it for them. Again, you cannot retrieve a patient's password- you can only reset it.

To reset a patient's password, on the *General Information* page in the *Login Information* box, click the pencil next to the *Web Login* heading. You can then reset the password (or enter a new password) for the patient. It is highly recommended that you reset the password, since this ensures that the patient will be able to change it when she next logs in. To do that, simply check the *Reset patient's password* box and click *Save Changes*. If instead you would like to manually enter a new password for the patient, uncheck the *Reset patient's password* box and enter the same new password info each of the two boxes.

Modifying a patient's Physicians

Each patient can have two providers assigned to her. This information can be entered when you initially enter the patient into Chronicle, or you can enter or modify the information on the patient's *General Information* page. To change this information (or to add it if it hadn't already been set), click on the *Assign* pencil above either the *Primary Physician (PCP)* or *Physician Responsible for Diabetes Management* box. This will bring up the list of all providers associated with your site. Select a provider from the list and click *Select Provider*. If the patient's provider has not yet been entered into Chronicle you can click *Add Provider* to enter the information. For more information about this process, see the section Primary Provider and PCP Management under Other Administrative Tasks.

Managing a patient's referrals

Each patient can have one or more educational referrals documented in their record. These referrals are listed on the patient's *General Information* page. To enter a referral manually (or to modify one that was already entered), click the *Add Referral* link above the *Referrals* box. This will bring up a window where you can enter a date for the referral, document who the Referring Provider was (or if it was a self-referral), and record a reason for the referral. Once you've entered all of this information click *Save Changes* to have it added to the patient's record. To edit an existing referral, click the pencil to the left of the referral. Click the red (-) sign to the right of an existing referral to delete it from the patient's record.

Managing a patient's educational sessions

All of the educational sessions that a patient is enrolled in will be displayed on their *General Information* page under the *Education Summary* box. Each class (or 1 to 1) is listed, with the individual class sessions listed below the class's name. Each class session lists the date of the class session, the name of the session, and the patient's attendance status for that session. Note that the patient's attendance status for all class sessions that have a scheduled data in the future will always be displayed as *Scheduled*. After the day of the class session has passed, the attendance will displayed will reflect the patient's actual attendance status.

Back to Top

The *Education Summary* box also allows you to quickly access a patient's existing class information or create a new 1:1 without having to first change to the *Education* tab. To quickly access a patient's existing class, click on the *Edit* pencil to the right of the class name. This will open the class's Diabetes Education and Progress Record (DEPR). For more information about editing the DEPR, see the sections Adding a New Class, Documenting a DSME class, and Documenting patient follow-ups under Class Administration. If you'd like to simply create a new class, click on the link *Click to create a new class* above the *Education Summary* box.

Managing a patient's cohorts

If a patient is a member of any cohorts, these will be displayed in a list at the bottom of the patient's *General Information* page. Next to each listed cohort is an *Edit* link that allows you to quickly edit the name of the cohort and the patients that are in that cohort.

DSME Assessment

Clicking the *DSME Assessment* tab from the left navigation pane displays a page with information about the patient as it relates to diabetes health. All of the information on this page will be populated by responses the patient gave on their initial patient self-assessment (PSA). The Health Risk Assessment (HRA) completed date at the top will reflect the date that the patient completed the PSA. If the patient did not complete a PSA then this page will not contain any information and can be filled out manually based on the information you gather from the patient. Any of the information on this page can be edited by clicking on the *Edit* pencil to the right of the section name. If you do fill out the HRA on behalf of the patient, you can enter the date that you completed the HRA into the yellow box at the top of the DSME Assessment page. Once this date has been entered the HRA/PSA is considered complete.

Health Status

Clicking the *Health Status* tab from the left navigation pane displays a page with information about the patient as it relates to their current (and recent) health status. All of the information on this page will be populated by responses the patient gave on their initial patient self-assessment (PSA). If the patient did not complete a PSA then this page will not contain any information and can be filled out manually based on the information you gather from the patient. Any of the information on this page can be edited by clicking on the *Edit* pencil to the right of the section name.

Behavior Change Objectives

Clicking the *Behavior Change Objectives* tab from the left navigation pane displays a page that lists all of the patient's behavior change objectives, including a full history for each objective. At the top of the page are two *Personal Goals* which are questions asked of the patient during the PSA. Below that, the *Objectives* section allows you to document how the patient's objectives (and her adherence to those objectives) change over time. You begin by adding a new (baseline) objective to the patient's record and indicating an achievement level. When you next follow up with the patient you can update the objective's status, recording the patient's new achievement level. By doing this you create a historical record of the patient's progress toward achieving their behavior change objectives. To the left of each objective is a disclosure triangle (either ▸ or ▼). Clicking anywhere on the objectives line will expand the objective to reveal all of the historical objective updates that have been recorded. Additionally, each objective update has a disclosure triangle, and clicking anywhere on the update line will expand the update to reveal details about the update.

Back to Top

Adding a new (baseline) Behavior Change Objective

After you have met with a patient and negotiated one or more *Behavior Change Objectives*, you can document each objective. To begin, click the *Add New Objective* button, which will bring up the *Add/Update Objective* window. Enter the following information:

- Behavior Change Objective Area – This is a drop down list of the seven objective areas defined by the ADA. Select the area that best matches the patient's chosen objective.
- Behavioral Change Objective – A description of the specific objective.
- Plan (real-world how-to-get to your objective) – A description of the action the patient will take to move towards this objective.
- Expected Outcome – A measurable outcome can be used to judge the patient's progress toward the objective.
- Baseline Objective Achievement – The patient's achievement level of this objective prior to education. This will typically be very low.
- Objective Status – Since this is the initial start of this objective, select Baseline.
- Objective Update Date – Enter the date that you negotiated this objective with the patient.
- Barriers for this objective were addressed – Check this box if you discussed barriers towards meeting this objective when you met with the patient.
- Notes (optional) – Any other information that you'd like to document specific to this patient's objective.

When you have completed this information, click the *Save Changes* button to add the objective. This will add the objective to the *Behavior Change Objectives* page, with the objective area listed in bold and the baseline objective status listed a line below.

Updating the status of an existing objective

After you have followed up with a patient and have gathered information about one of her objectives, you can document this by adding a new Objective Update to the objective. Begin by finding the objective name that you set up during baseline. Then click on the *Update this Objective* link to the right of the objective name, which will open the *Add/Update Objective* window. Note that the *Objective*, *Plan*, and *Expected Outcome* are already pre-populated with the information that was entered at baseline. If any of these have changed, you can edit the information to reflect the changes. You are required to enter a new *Assessed Objective Achievement* to indicate how the patient has progressed. Enter the *Objective Status* to indicate if the objective was Continued, Modified, or Discontinued. The *Objective Update Date* is the date that you spoke with the patient and got the updated progress information. After indicating if barriers were addressed and adding any optional notes, click the *Save Changes* button to add the status update to the objective.

Viewing and editing an existing objective status

The *Behavior Change Objectives* page shows the patient's objectives with each status update to the objective listed below the objective name. To view details of an objective status, click the ▸ button to the left of the status update listing. This will reveal the details of that status update. To hide these details, click the ▼ button. Typically you won't need to edit an objective status- updates to an objective should be documented by adding a new objective status update. The only time would be if you made a mistake entering the information or if you needed to add missing information. To edit an objective status, begin by clicking on the *Edit* pencil to the left of the status line, which will open the objective status window. Make any necessary changes and click the *Save Changes* button.

Clinical Data and Labs

Clicking the *Clinical Data and Labs* button from the left navigation pane displays a page that lists all of the most recent clinical data and lab information for the patient. For a new patient with no

Back to Top

clinical data or labs documented, the main middle section of this page will be empty and the full list of *Available Tests* will be displayed on the right side of the page. As test values are documented, those values will be displayed in the main middle section and the test will be removed from the *Available Tests* lists. Each listing in the main middle section lists a test and the most recent results for that test. By clicking on a specific test line, the listing will expand down so you can see a complete history of results for that test. If there are multiple historical test results recorded for a test, then clicking on a specific test result will expand that result down and reveal additional details.

> Tip: When a patient completes an initial patient self-assessment (PTA), they are able to enter test results for a few of the tests.

Adding a new clinical data or lab test result

After you have gathered clinical data or lab results for a patient, you can enter both the most recent values as well as historical values into Chronicle. To enter a test result for a test that doesn't have any previous data, begin by clicking on the test's name in the *Available Tests* lists. Alternatively, if the test already has one or more previous results and you're going to be adding another test result, click the *Add Results* link to the right of the test's name. Doing either of these will bring up the *New Lab* window. Enter the following information:

- Test result – This is the result of the specific test. Note that the format of the results will be specific to the type of test. E.g. *HBA1c* requires a numerical value, whereas *Flu Vaccine* simply lets you indicate it was performed.
- Date Performed – The date that the test was performed. If you are unsure about the date that the test was performed, enter an approximate date and check the *date is approximate* box to indicate that uncertainty. If you don't know the date at all, check the *do not know the date* checkbox to indicate that you don't know.
- Source of data – Each data point entered into Chronicle is required to have its source indicated as well. Select the source from the drop down list. If the source of the data isn't listed in the drop down you can indicate it as *Other*. Select *Other (verified)* if the data source is considered reliable. Select *Other (unverified)* if the data source suspect or unknown.
- Notes – Any additional notes about this specific test result.
- Provider – Click the *Select* pencil to open the *Select a Provider* window. Select a provider and then click *Select Provider*. If the provider who provided the test result is not already in the database, you can add them by following the instructions in Primary Provider and PCP Management under Other Administrative Tasks.

When you have entered all of the information, click the *Save Changes* button to save the test result. If the value you just entered is the most recent value for that test, then the new value will be displayed in the center table.

Adding multiple clinical data or lab test results using a Lab Sheet

If you are going to be entering multiple clinical data or lab test result values that all share the same common information you can use a *Lab Sheet* to speed the entry. Click the *New Lab Sheet* link in the upper right above the *Available Tests* lists. This will bring up the *New Lab Sheet* widow. Enter the common information at the top of the window, and then fill out the all of the clinical data or lab test results that you have. Note that all of the data entered on the *Lab Sheet* will share the same Common Information. Also, when the Lab Sheet is saved, the individual test results are all stored individually- they're not stored as a single lab sheet. Thus using a Lab Sheet is really just a way to automate the process of adding multiple individual clinical data or lab test results.

Back to Top

Editing or deleting an existing test result

Typically you won't need to edit or delete an existing test result- new test results should be documented by adding a new clinical data or lab test result, not by editing existing results. The only time you should edit existing test results would be if you made a mistake entering the information or if you needed to add missing information. To edit an existing test result, begin by clicking on the test in the main middle section, which will expand the test down to reveal the historical results. Click on the specific test result that you'd like to edit (which will expand that individual result) and then click the *Edit* pencil icon. This will open the *Edit Lab* window where you can make any necessary corrections and click the *Save Changes* button.

If you had previously entered an erroneous test result, you can delete the test result. Click on the specific test result that you'd like to delete and then click the red *Delete* icon (—) and confirm the deletion in the following box.

Medications

Clicking the *Medications* tab from the left navigation pane displays a page that lists all of the medications that the patient is taking or was taking in the past. Each listing in the center table lists a medication and the most recent information about that medication. By clicking on a specific medication line, the listing will expand down to reveal a complete history of *Medication Change Events* for that medication. Clicking on a specific *Medication Change Event* will cause it to expand down and reveal any notes for that event.

Adding a medication

After you have gathered the medications information for a patient, you can enter both the patient's current medications as well as historical medication or medication change events into Chronicle. To enter a new medication, click the *Add New Medication* link (near the top right of the *Medications* page) to bring up the *Start New Medication* window. This box allows you to enter a new medication for this patient. The *Quick List* on the right contains medications that you've previously marked as a favorite (marked with solid stars) as well as other popular or recent medications (marked with empty stars). The boxes on the left allow you to select a medication that isn't already in your *Quick List*. To add a new medication that isn't in the *Quick List*, enter the following information:

- Medication - start typing the name of the medication in the trade name box. Once you've entered the first few letters a list will appear with matching medications. As you continue to type, the list is refined. When you see the medication that you want to add, you can click on it with your mouse or select it using your arrow keys and then hit enter. If your medication isn't in the list (e.g. if you're entering an herbal supplement), you can add it to the database by clicking the first entry in the list that says *Add a new medication named [name]*. Clicking this option will bring up a link that says *Click to add "[name]"* to add it as a custom medication to the database. See the section Creating a new (custom) medication for more information. Otherwise, just select your medication from the list by clicking on it.
- Dosage/Strength – When you click into the *Dosage/Strength* box, all of the predefined dosages for that medication will be displayed in a list. Select the dosage from the drop down box. If the dosage you want is not listed, you can just enter it into the *Dosage/Strength* box.
- Date – Enter the date that the patient started on the medication. If you only know the approximate date that the patient started on the medication, click *Date is approximate*. If you don't know the date at all, click *Do not know start date* and don't enter any date.
- Frequency – Enter the frequency with which the patient takes the medication (e.g. b.i.d.). Note that the box will auto-complete the entry with common abbreviations as you type. If the frequency is not listed, you can just enter it into the *Frequency* box.
- Notes – Enter any additional notes related to the medication's start.

Back to Top

If the medication that you just entered is one that you believe you'll be using frequently, you can add it to the *Quick List* by clicking the link *Add medication to favorites* link next to the medication's name. This will add the medication to the *Quick List* and give it a solid star, meaning that it will remain in the list until you decide to un-favorite it. You can un-favorite a medication in the *Quick List* by clicking the solid star, making it an empty star. Note that the medication will likely remain in the list for some time, since the list shows all recently used medications. In the future you can quickly load a medication from the Quick List by simply clicking on the medication in the list.

When you have entered all of the information, click the *Save Changes* button to save the new medication.

Recording a medication change event

If a patient's prescribed medication regiment changes (e.g. the dosage or frequency of a medication that they are on is modified), you can document this information by recording a medication change event. Click the *Record Medication Change Event* link to the right of the medication's name, which will bring up the *Record Medication Change Event* window. Here you can enter the date that the medication change event took place. Then enter the new dosage and frequency for the medication, and any notes that you'd like associated with the change of this medication. When you have entered all of the information, click the *Save Changes* button to save the medication change event. You'll see that a new line will have been added under the medication's listing.

Editing or deleting an existing medication or change event

Typically you won't need to edit or delete an existing medication or change event- changes in medication should be documented by adding new medication change events. The only time you should edit existing medication events is if you made a mistake entering the information and needed to correct it. To edit an existing medication or change event, begin by clicking on the medication's listing in the center table, which will expand the medication listing down to reveal all of the existing change events (including the start event). Click on the specific change event that you'd like to edit (which will expand that individual event) and then click the *Edit* pencil icon, which will open the *Edit Medication Change Event* window. Make any necessary changes and click the *Save Changes* button.

If you had previously entered an erroneous medication, you can completely delete the medication from the patient's record. Click on the specific medication that you'd like to delete and then click the red *Delete Medication* icon (—), and confirm the deletion in the following box.

Recording a stop medication event

If a patient is no longer taking a medication that they had previously been prescribed, you can document this information by recording a stop medication event. Begin by clicking on the medication's name in the main medication table. Then click the *Stop Medication* link to bring up the *Stop Medication* window. Enter the date on which the patient stopped taking the medication and any associated notes. When you have entered all of the information, click the *Save Changes* button to save the stop medication event. You'll see that the medication has been removed from the *Current Medication* table down into the *Stopped Medications* table.

Creating a new (custom) medication

If a patient is taking a medication that is not already in the database, you can manually add the medication to your site's medication database so that it will be available for future use. Begin by trying to add the medication to a patient's record- click the *Add New Medication* button to bring up

Back to Top

the *Start New Medication* window. Type in the *Trade Name*, and if the medication isn't already in the medication database you'll be presented with no matches but will have an option to click *Add a new medication named [name]*. Clicking this option will bring up a link that says *Click to add "[name]" as a custom medication.* Clicking that will add the medication you entered as a new medication in the database. From then on it will be available to all your site's educators in the medication's list in the future.

Contact History

Clicking the *Contact History* button from the left navigation pane displays a page that allows you to record and view contacts that have been made or attempted with the patient. Initially patients don't have any contacts. To document a new contact event, click *New Contact Event*, which will open the *Patient Contact History* window. Enter a date for the event, select the *Reason for Contact,* and the *Result of Contact*. If the results was *Did not reach*, select the *Reason for not reaching*. If there is any other information that you'd like to record you can enter it in the *Notes* box. When you are done click *Save Changes*. This will add the contact event to the list of events for the patient. You can also edit or delete existing contact event using the Edit and Delete links.

Notes

Clicking the *Notes* button from the left navigation pane displays a page that allows you to record and view free-text notes about the patient. Initially patients don't have any patient-specific notes. To add a new patient-specific note, click *Add New Note*, which will open the *Add / Edit Note* window. Enter a date for the note and type the note into the *Notes* box. When you are done click *Save Changes*. This will add the note to the list of notes for the patient. You can also edit or delete existing notes using the *Edit* and *Delete* links.

Below the patient-specific notes are both class-wide notes and session-specific notes. These are notes that are recorded for classes that the patient is in. Each class that the patient is in will be listed, and any class-wide notes will be displayed. Also, any session-specific notes will be displayed for all the sessions that the patients attended (e.g. if the patient's attendance is listed as ATT). For more information about creating class-wide notes, see Documenting additional comments and notes under Documenting a DSME class.

Back to Top

Class Administration

To access the class administration section, click on the *Education* tab in the top navigation bar. This will display a list of all of the classes currently entered at your site. Note that if you already have a class record open you will have to click on the *Return to Class List* button to return to the full list. In Chronicle, the term "Class" can be though of as a container that has information including:

- General information about the class
- A schedule of one or more educational sessions
- A roster of patients enrolled in the class
- An attendance list of patients who attended or were absent for each class session
- A lesson plan documenting what was taught at each of the educational sessions
- Documented assessments of individual patient comprehension both pre and post education, and also at follow-up.

All education is referred to as a "class", even if the education was conducted 1-on-1. A 1:1 DSME event is just considered a class that has only one person in it. All classes consist of one or more educational sessions. A patient can be in zero, one, or more classes. In Chronicle, all classes are documented in a tool called the Diabetes Education and Progress Record (DEPR).

View complete list of classes

The *Class List* page gives you a list of all of the classes currently entered at your site. Note that if you already have a class record open you will have to click on the *Return to Class List* button to return to the full list. The list of classes is shown in groups of 25. Use the navigation at the top right of the classes list to page through all of your classes. To search for a specific class, enter into the *Search* box any part of the class's name. Click on the *X* to the right of the search box to clear the search (and see the full class list).

In each class row listed in the *Class List* is a link to *Generate Letters*. This will allow you to generate a letter for everyone in the class. This function is discussed in detail in the section Generating Patient Letters. Clicking on a single class line will open that class's record.

Creating a new class or new 1:1

> **IMPORTANT:** If you are assigned to multiple sites within your program, then be sure that you are viewing the correct site before adding a new class. New classes are added to the site that you're currently viewing. For more information about witching between sites, see the section Switching between sites under Log In and Log Out.

New classes can be created "from scratch" or can be created form a class template that you can set up. In this section we will cover creating a class from scratch. For detailed information about setting up and using class templates, see the section Managing and using Class Templates below.

Since documenting both a group class and a 1:1 education are done though the DEPR, the process is very similar. However the way to start the process is slightly different. First, make sure you're on the *Class List* page. To add a new group class to your site from scratch, click on the *Create New Group Class* button to bring up the *Create Group Class* window. Enter a name for the new class. Choose a logical name that will allow you to uniquely identify the class when you see it in a list of all classes. You can select any name that makes sense to you and your office staff. Examples for class names could be "June 2011 Monday AM" indicating a class that has multiple sessions occurring on Monday mornings in June. You must also indicate the *Class Type* (Comprehensive or Post-program) and the *Education Format* (which in this case will be Classroom/Group). After you have entered the class name, click *Save Changes*. This will open the Diabetes Education and Progress Record (DEPR) for the class. You'll notice that the *General Information* tab is selected in

Back to Top

the menu on the left. On this *General Information* page of the DEPR there are a number of sections that need to be completed for the class documentation, which are described below.

To start adding a new 1:1 education, click on the *Create New 1:1 Session* button to bring up the *Create New 1:1 Session* window. Note that before creating a 1:1 session for a patient, the patient must already have been entered into Chronicle (see Creating a New Patient). Begin typing the name of the patient who will be in this 1:1. Note that you need to have already added this patient to Chronicle. After you've typed the first three characters of the name, a list will display all matching patients. You can continue typing the name until you see the name of the patient, at which point just click on the patient's name to select it. Next, enter a name for the new 1:1 class. Choose a logical name that will allow you to uniquely identify the 1:1 when you see it in a list of all classes. You can select any name that makes sense to you and your office staff. Examples for class names could be "Initial visit" indicating the first time that you will be seeing the patient. You don't need to include the patient's name as part of the name since Chronicle will automatically show the patient's name in the list of all classes. Indicate the *Class Type* (Comprehensive or Post-program). Then enter the date and (optionally) time that the 1:1 session will be occurring. If you will be meeting with this patients for multiple sessions, just enter the date and time of the first session. Finally, enter the *Duration* and *Type of Intervention* (DSME or MNT). Note that if you aren't sure about any of these fields (e.g. if you are not sure how long the session will last), just fill in the anticipated values. You can always change the information later.

> **TIP:** Entering the *Session Time* is optional, but if you do enter it and then generate a Welcome letter for the patient, then both the upcoming session date and time can be listed in the letter.

After you have entered all of the information for the 1:1, click *Save Changes*. This will open the Diabetes Education and Progress Record (DEPR) for the 1:1. You'll notice that the *General Information* tab is selected in the menu on the left. On this *General Information* page of the DEPR there are a number of sections that need to be completed for the class documentation, which are described below.

Entering Class Information

After the class is initially created, you can enter additional details to the *Class Information* box. Click on the *Edit* pencil above the *Class Information* box to open the *Update Class Information* window. You can enter the education location and language, and select the relevant *Instruction Methods* and *Education Materials*. After you have entered the information, click *Save Changes*. You'll notice that the *Class Information* box is updated with the information you entered.

Defining Class Schedule

Each class consists of one or more class sessions. Each class session occurs at a specific date and time, and can have specific educational topics documented as being taught during that session. For example, if the class you are creating will meet four times (e.g. every Monday at 10AM for four weeks), you'll define four class sessions. These sessions will be listed in the *Class Schedule* box. Initially this list is empty for new group classes (1:1 classes will list the initial session you defined when you set up the 1:1). To add a new class session, click the *Add Session* link above the *Class Schedule* box, which will bring up the *Create New Session* window. This session should have a descriptive name. Examples of session names could be "Initial assessment", "Introduction and MNT", or simply "First session". You can also enter the date and time that the session will occur, which will allow the system to include this scheduling information when you generate a letter to the patient. Finally, you must enter the type of intervention (DSME or MNT) and duration (length in minutes and hours) of the class session. Optionally, you can enter a Session Note that will apply only to this session, and will only appear on a patient's record if the patient attended this specific session (e.g. if the patient's attendance is listed as ATT). After you have entered the information,

Back to Top

click *Save Changes*. You'll notice that the new class session is added to the list. If your class will be meeting four times, you'll repeat this process four time to define the four sessions. If you need to change any of the information about the session, click the editing pencil to the left of the session name.

After you have defined the class sessions you'll notice that they are listed in the *Class Schedule* box with a number and a color to the left of each session. These colors and numbers will be used in the other tables below as column headers to represent the sessions.

Editing or deleting an existing class session

If you need to delete a session (e.g. if a session had to be canceled), click on the red delete (–) icon to the right of the specific session that you'd like to delete. After you confirm the deletion the session will be removed. If you'd like to edit an existing session (e.g. if a session had to be rescheduled or you want to rename it), click on the edit pencil to the left of the specific session that you'd like to edit, which will open the *Update Session* window. Make any necessary changes and click the *Save Changes* button.

Entering and editing the class roster

Every class has one or more patients, each of whom is listed on the class roster. To add patients to a new class, begin by clicking the *Update Roster* button, which will open the *Update Class Roster* window. This window uses Chronicle's standard patient selector. The column on the left (*Recently Added Patients*) lists all of the patients that were recently added to your site. The column on the right (*Current Roster*) lists the patients that are members of this class. Alternatively, you can search for a specific patient on the left. To add a patient to this class, find her name in the left column and click on her name. This will move the patient from the left column to the right column, thereby adding the patient to the roster for this class. To remove a patient from this class's roster, click on the patient's name in the column on the right. When you're done, click the *Save Changes* button to close the window. For more information about using Chronicle's patient selector, see the section Patient selection interface under Other Administrative Tasks. After you have entered the patient roster you'll notice that they are listed in the *Class Roster and Attendance* box, with the word "ATT" (meaning attended) listed in each of the session columns. Chronicle defaults to attended since it is assumed that at the time patients are scheduled they are planning to attend every class session. If some patients do not attend a class session you can document this via the *Update Attendance* window. For more information about documenting attendance, see the section Documenting patient attendance under Class Administration. Also displayed in the *Class Roster and Attendance* box is each patient's *PSA Status*. If the patients has started or completed the online PSA, that status will be indicated here. Alternatively, if you manually entered a date that the Health Risk Assessment (HRA) was completed (on the top of the patient's *DSME Assessment* page) then the PSA status will be shown as *Completed*. If the patient did not start or complete the PSA, and you didn't enter a date that the HRA was completed, then the status will be shown as *Not Started*.

Exporting a patient list for a class

After setting up the class you might want to export that list of patients into an Excel format. Once you've export the list, you could then use the functionality in Microsoft Word to do a mail merge and create letter or mailing labels for the class. Below the *Class Roster and Attendance* box is a link to *Export Patient List*. Clicking this link will prompt you to download an Excel file that contains information about each patient on the class roster.

Back to Top

Sending letters to every patient in a class

After setting up the class you might want to send welcome letters to every person in the class. These letters can contain information about the upcoming class as well as individualized information for each patient. If you're already within a class record, you can click the *Generate Letters* link below the *Class Roster and Attendance* box. Alternatively, if you're on the Class List page you can find the row for desired class and click the *Generate Letters* link. This will bring up the *Letter Wizard* window, and all of the patients on the class roster will be included in the *Patient to receive letters* list. Follow the instructions in Generating Patient Letters under Patient Administration to complete the generation of the letters.

Documenting a DSME class

The DSME documentation process adheres closely to the recommendations and requirements of the American Diabetes Association. Documentation is built around the nine learning objectives, allowing you to specify if and when each of these objectives will be covered during the course of DSME. Chronicle then allows you to record a Pre Assessment and a Post Evaluation of the patient's achievement level towards each of the objectives. Chronicle also provides a way to track patient attendance as well as educator time spent with the class. The instructions below describe the steps of documenting a complete DSME session. All of these steps are normally completed after the education has occurred, with the exception of Defining the lesson plan for the class. The lesson plan can be defined either before or after the education occurs.

Defining the lesson plan for the class

The lesson plan allows you to specify which of the nine learning objectives was covered during the class, and during which class session each objective was covered. Begin by clicking the *Lesson Plan* tab in the left navigation pane. The *Lesson Plan* page lists each of the learning objectives, with nothing listed under the *Dates of Instruction* column. Click the *Edit Lesson Plan* link near the top right, which will open the *Update Class Lesson Plan* window. The nine objectives are listed, and to the right (under the heading *Dates of Instruction*) are one or more colored columns representing each of the educational sessions that were defined previously. Note that if there aren't any colored columns displayed then you need to go back to the *General Information* page and follow the instructions Defining Class Schedule under Creating a new class or new 1:1. For each objective that was covered, check the check box to the left of the objective under each session column where that topic was covered. If you covered the objective during more than one session, you should check each column where it was covered. Every topic that was covered at any point during this class should be checked at least once. Any topic that does not have a check under any of the session columns is considered to have not been taught during this class.

Documenting individual patient educational progress, barriers and support plan

The documentation of educational progress for everyone in the class is done on a patient-by-patient basis. Note that all of the patients in a class are listed under the Patients heading in the left navigation pane, and each patient has a (‣) to the left of their name. Click the (‣) next to the first patient that you want to document. This will reveal the *Education* and *Follow Up* tabs for the patient. Click on the *Education* tab to show the educational assessment page for the first patient. At the to of the page is the *Education Plan* for the patient. Click *Edit Education Plan* to enter the information. Below that is the *Patient Education Record*. All of the ADA learning objectives are listed, and each objective that you previously indicated on the *Lesson Plan* page will be active (un-dimmed). If you previously indicated on the *Lesson Plan* page that all of the objectives were covered then all of the objectives will be active on the patient's *Education* page.

For each topic you need to specify a *Pre Assessment* and a *Post Evaluation* for this individual patient. Begin by clicking the *Edit Education* link above the *Patient Education Record* table, which

Back to Top

will open the *Update Patient Education* window. This window displays each of the nine topics and has two colored tables for *Pre Assessment* and a *Post Evaluation* scoring. Note that any topics not indicated as having been taught in the *Lesson Plan* will be grayed-out and you won't be able to record any assessment. For each of the nine areas that you did teach, you should check a box in the *Pre Assessment* and *Post Evaluation* columns to indicate this patient's level before and after education. Rate each topic on the scale of 1 to 4, using the color key at the top of the window for reference. You can also enter any *Comments* related to the patient's progress toward that specific objective. When you've completed this, click *Save Changes* to close the window. You'll notice that the *Patient Education Record* table is updated with the new information.

> **TIP:** You can quickly enter a single score for all of the topics by clicking on the number at the top of the column. For example, if a patient was assessed at a level of "1" (*Needs instructions*) for each of the nine topics, you can click the blue *1* at the top of the column. This will place a check mark into each of the boxes in that column. You can then modify the score for an individual topic by checking other boxes if the assessment for that topic is different. For example, if the patient just needed review of *Using medication safely*, click the box under the green *2* column to change the assessment for just that topic.

After all of the educational progress (pre and post) for this patient has been documented, click on the *Edit Identified Barriers* link to open the *Update Identified Barriers* window. Enter any barriers and click *Save Changes* to close the window. Finally, click on the *Edit Support Plan* link to open the *Update DSMS Plan* window. Enter the patients DSMS plan and click *Save Changes* to close the window. Note that you should not fill out anything under the *Follow Up* tab at this time- this is only used at follow up (e.g. three or six months after DSME).

At this point the documentation of DSME for this individual patient is complete. You can click the (‣) to the left of this patient's name to collapse the sub-menu for this patient. You can the click the (‣) on the next patient that you'd like to document and repeat the procedure you just completed. Continue repeating this procedure for each patient in the class until you've documented education for all of them.

Documenting additional comments and notes

Each class DEPR has a section for additional information that you'd like to document, but that didn't fit under any of the other documentation areas. To access this, click on the *Class Notes* tab and then on the *Update Class Notes* link. This will display a large text box. You can type anything into this box that you'd like to document. This text box can be updated, added to, and edited in the future. Note that *Class Notes* are for notes that apply to the entire class of patients. If you'd like to record a note for an individual patient, you can enter those under the *Patient Notes* in the individual patient's record. See Notes under Patient Administration for more information.

Documenting patient attendance

Chronicle's ability to track patient attendance integrates with the *Lesson Plan* making it easy to document which patients received education on each objective. Since the *Lesson Plan* defines what educational objectives were taught during each class session, an accurate attendance record of which patients were present at each class session is important to in order to maintain an accurate record of what education each patient received. For example, if a class met for four sessions, you might have taught *Using medications safely* during the second class session. You would have documented this in the *Lesson Plan* for session two. If patient Nancy Henderson missed session two and you don't update the *Attendance* table to indicate this, then Nancy's education record will show her as having had education on *Using medications safely* during the second session. However if you update the *Attendance* table to show her absence, then her overall education record will not

Back to Top

include *Using medications safely* (unless she made up the education by attending another class or session that covered it).

By default, all patients are marked as *ATT* (attended) for each class session. If all of the patients on the roster did attend each session, then no further updating to the attendance list is required. However, if some patients were absent then you'll need to update the attendance list. To begin, click on the *General Information* tab in the left navigation pane. The *Class Roster and Attendance* table lists each patient and their attendance status under each of the colored session columns. To update this information, click the *Update Attendance* link above the table, which will open the *Update Class Attendance* window. Each patient on the class roster is listed and there is a column for each of the class sessions. Under each session column is listed the attendance status for each patient. To change a patient's attendance status for a class session (e.g. if they missed a class session), select the appropriate attendance status from the drop down menu under that session's column. Use the *Key* at the top of the window for reference. Use the status of "N/A - Not Applicable" for a patient that did not need to attend a class session. For example, if a patient misses a session in January's four-session class, she might complete her education by attending just one of the sessions in February's class. Thus the other sessions in February are not applicable to the patient. Repeat this procedure of updating the status for each of the class sessions that were missed. When you are finished editing the class attendance you can save and close the window by clicking *Save Changes*.

Documenting educator time spent with class

Chronicle allows you to track the time that each educator provided during each class session. Note this Educator Time section of the class record is optional and is not used to calculate time for future ERP Application submissions. All ERP Application submission time data is calculated from the session length defined for each sessions listed under the Class Schedule.

To document this information, first click on the *General Information* tab in the left navigation pane. Above the *Educator Time Spent* box, click on the *Update Educator Time* link, which will bring up the *Update Educator Time Spent* window. Here you can specify which educators contributed to the class, and how much time they spent on each class session. The table lists all of the educator associated with your site. Note that if there is an educator or other staff member at your site that is not listed in the table, you will need to ask your Program Coordinator to add or associate the staff member using the ADA ERP portal. For each educator that contributed to the class, check the box to the left of their name. Then, under each session that they contributed, fill in the number of minutes under the appropriate session column. Note that you can have more than one educator contributing to a class session, and each educator can contribute to more than one session. Once the first educator's times have been entered, repeat the process for each additional educator that contributed time. When all of the educators have been entered and all of their time contributions documented, click the *Save Changes* button to close the window.

Documenting patient follow-ups

When it's time to conduct patient follow-ups (e.g. 3-6 months after a DSME class), Chronicle provides a concise way to document patient adherence to the learning objectives and progress towards their established behavior change objectives. Follow-up documentation is done on a patient-by-patient basis within the class DEPR, as recommended by the ADA. The DEPR for the class a patient was in can be accessed one of two ways. If you're already within the main *Education* section of Chronicle you can select the appropriate class from the *List View* to open the DPER. However a quicker way to access a patient's DEPR is from within the main *Patients* tab. To access the correct DEPR for the patient on whom you'd like to document follow-up, first click on the *Patients* tab and open that patient's record. If you were already on that patient's tab, ensure that you're on the patient's *General Information* page (from the left navigation menu). Under the

Back to Top

Education Summary are listed all of the classes the patient participated in. (Typically there is just one class unless the patient participated in more than one class.) To launch the DEPR for that class, click on the Edit pencil icon to the right of the class's name. This will take you to the DEPR for that class.

In the DEPR window you will see the list of patients in the left *Navigation* menu. Click on the (‣) to the left of the patient you want to document, which will expand the menu items under the patient. Click the *Follow Up* tab to view the *Patient Follow Up Record*, and then click the *Edit Follow Up* link to open the *Update Patient Follow Up* window. First, select your name for the *Clinician Signature* drop down list (unless someone else conducted the follow-up), enter the *Date of follow-up*, and select the *Follow Up Method*. Below that are listed the *Topic/Learning Objectives* that were covered during this class. Note that objectives that were not covered in this class are dimmed. For each objective, check the appropriate *Reassessment* box to indicate this patient's level at follow up. Rate each topic on the scale of 1 to 4, using the color key at the top of the window for reference. You can also enter any *Comments* related to the patient's progress toward that specific objective. When you've completed this, click *Save Changes* to close the window. You'll notice that the *Patient Follow Up Record* table is updated with the new information.

After all of the educational follow up reassessment for this patient has been documented, click on the *Edit DSMS Plan* link to open the *Follow Up DSMS Plan* window. Enter the patients DSMS plan and click *Save Changes* to close the window.

The other aspect of follow up documentation is recording each patient's progress with their selected behavior change objectives. To document this, follow the instructions Updating the status of an existing objective under Behavior Change Objectives under Patient Administration.

Managing and using Class Templates

Classes can be created "from scratch" or can be created form a class template that you can set up. In this section we will cover setting up a class template and using that template to create a class. For detailed information about creating a class from scratch, see the section Creating a new class or new 1:1 above.

Class templates allows you to set up a template for a typical class, including the general information for the class, the class session structure, the educator time spent during each session, and the lesson plan for the class. Once a template is defined, you can quickly create new class based on this template, and then just customize the unique elements of the class (e.g. add patients to the roster, set the session dates, etc.). Multiple templates can be set up and used as needed.

Creating a new Class Template

Since documenting both a group class and a 1:1 education are done though the DEPR, the process is very similar. First, make sure you're on the *Class List* page. To create new class template, first click the *Manage Templates* link in the *Class Templates* section of the left navigation pane. This will open the *Manage Templates* window, which contains a list of all of the templates that have been created at your site. To add a new template to the list, click the *Add New Template* button. Give the template a name that clearly describes the type of class this will be used to create. For example, if you have a standard monthly class that consists of three sessions taught on Monday mornings at 9AM, you might call the class "Monthly, 3 Mon AM sessions".

You will now be on the tab where you can define the *General Information* for the class. Fill as much information out on this tab as will be common to all classes created with this template. Nothing is required (other than the *Template Name*), but the more information you fill out, the more

Back to Top

information will be pre-populated when you create the class. For example, if all classes created with this template will share the same *Class Type*, *Education Format*, *Location*, and *Language*, and *Instruction Method*, (but will differ on the *Education Materials* provided), then fill out all of the common fields.

The *Class Sessions* tab allows you to define the sessions that each class will have. In our example, the class template will have three sessions on Monday at 9AM. Check the check boxes to the left of the first three sessions. For each session give it a name, intervention type, duration, time, and a note. All of these are optional in the template, and can be added later when you're creating the class. The *Educator Time* tab allows you to define how much time each educator will contribute to each of the sessions. The *Lesson Plan* tab allows you to define which educational topics will be covered during each of the sessions. The *Class Note* tab allows you to enter a note that will apply
to all patients in the class. All of the information on all of the template's tabs is optional, but will speed the creation of classes in the future. Also, any information you enter in the template can be later modified after you have created the class.

When you are done entering all of the information for the class template, click *Finish and Close* to return to the *Manage Templates* table. If you ever want to edit an existing template, click on the template's name and click *Edit Selected Template*. Note that editing a template does not modify classes that were previously created from that template. When you are done managing the templates, click *Finish and Close Window* to return to the *Class List*.

Creating a new Class from a Class Template

To create a new class form an existing class template, select the class template from the dropdown list in the *Class Templates* section of the left navigation pane, then click *Create Class From Template*. This will open up the *Create Class from Template* window, with all of the information from the template already populated into the class. Here you can add any additional information, making sure that all required fields (with red underlines) are completed. Note that if your class template included one or more sessions, you will need to fill in the session date for each session. When all the class information is correct, click *Save Changes*, which will create the class and automatically open the class to the *General Information* page. Next you can follow the normal class creation process by updating the patient roster. For information about editing the patient roster
and documenting the education, see Entering and editing the class roster and Documenting a DSME class.

Back to Top

Other Administrative Tasks

There are a number of administrative tasks that apply across multiple sections of Chronicle, which are detailed below.

Primary Provider and PCP Management

Your Chronicle site maintains a list of the providers related to your program. This list is shared among all of the educators at your site, and among all sites in your program, so changes you make to it are available to everyone within your program. You can access and manage this list from a number of locations- from the *Provider / Physician* section of a patient's *General Information* page; from within the *Create New Patient* window; or when identifying a Provider for a new *Test Result* under *Clinical Data and Labs*. The *Select Provider* window will display a list of the current providers. To add a new provider to the list, click the *Add Provider* button to bring up the *Create New Provider* window. Only the *First Name* and *Last Name* are required, however additional information you enter here can be used in other sections of Chronicle. For example Chronicle can generate letters that are addressed to patients' providers.

If you have multiple providers working at the same site, you can create that site using the *Provider's Site* interface. Click the *Select Site* link to the right of the *Provider's Site* text box to bring up the *Select Provider Site* window. Add a new site by clicking the *Add Site* button and entering the site's information. Once you've created the site you can assign the provider to that site by clicking on the site's listing and then clicking the *Select Site* button.

After you've entered all of the information for the new provider, click *Save Changes* to close the window. You can then select the new provider from the list and click *Select Provider* to close the window. If you need to edit an existing provider, select the provider from the list and click *Edit Selected Provider*. Make any necessary changes and click *Save Changes*.

Letter Management

Chronicle can store numerous letter templates that can be used to generate letters for your patients. To manage those letters, launch the *Letter Manager* by clicking the *Launch Letter Manager* button from within a patient's record or when on the *Education* tab, by clicking the *Generate Letters* link for a class and then clicking *Launch Letter Manager*. From here you can edit an existing letter, create a new letter, or delete an existing letter.

To begin editing an existing letter, select the letter from the *Chose a letter to load…* drop down list at the top of the wizard. That will load the letter template in the main text area. Edit the text of the letter using normal text editing steps (type, delete, etc.). To format text, select a section of text and use the formatting bar directly above the main letter area to boldface, italicize, underline, justify, or indent the text. To insert a custom tag (e.g. current date, patient's name, etc.) that will be replaced when the letter template is merged with patient data, start by positioning the cursor (i.e. move the blinking vertical cursor bar) where you would like the tag to go. Next click on the *Insert Custom Tag* menu and then select the tag you would like from the menu. This will insert a yellow tag into the letter, which will be replaced with the corresponding data when the actual letter is generated. After you've made the changes to the letter, be sure to click the *Save* button to save your changes.

An existing letter can be renamed (i.e. change the name of the letter as it appears in the dropdown menu) by clicking the *Rename* button. If you'd like to create a new letter, there are two ways you can do it. If the letter is going to be similar to an existing letter, you can use that existing letter as a starting point. Select the existing letter from the drop down list, and then click the *Duplicate* button and give the new letter a new name. This will create a new letter that you can edit and save when complete. Alternatively, if you want to create the new letter from scratch, click the *New*

Back to Top

Blank Letter button and give the new letter a name. This will create a new blank letter that you can edit and save when complete.

To get a preview of a letter, click the *Preview* button, which will generate a sample letter that you'll be prompted to download to your computer for viewing. To delete a letter, select the letter from the drop down list and then click the *Delete Letter* button.

Patient selection interface

Chronicle uses a standard patient selector in instances when a subset of patients needs to be selected from the entire patient population. For example, the patient selector is used when defining the patients who are in a class, a cohort, or who will receive letters. The patient selector consists of two columns. The column on the left (*Recently Added Patients*) is a list of all of the patients that are currently in the system. The column on the right is specific to the patient subset (e.g. class or group) that you're managing, and will list the patients that are members of the subset. To search for a specific patient, enter into the *Search* box any part of the patient's name, which will display a list of matching patients. As you continue to type, the list is refined. When you see the patient that you want to add, you can click on the patient with your mouse or select it using your arrow keys and then hit enter. Clicking on a patient from the *Recently Added Patients* list or from the *Search* list will add the patient to the column on the right (and thus the subset). When you're done, click the *Save Changes* button.

Date Entry

There are two ways to enter dates into Chronicle, which apply to all date fields. The first (and usually quickest) is to type the date directly into the date box using the format M/D/YYYY. So for February 18, 1938 you would type "2/18/1938". Note that you do not need to have a leading "0" for single digit days and months (e.g. you don't need to type "02/18/1938"), although you can if you would like. Also note that you do need to enter the full four digits of the year (e.g. you can't type "2/18/38" but must enter the full "2/18/1938").

As an alternative to directly typing the date, you can use the calendar widget to enter the date. Begin by clicking the calendar icon to the right of the date box. This brings up a mini calendar. To select a specific year, click on the currently selected year to display a list of all years, then select the desired year from the list. To change months, use the left and right arrows at the top of the calendar to change months. Finally, click the specific day of that month. This will close the calendar widget and copy the selected date into the date box.

Back to Top